

§ 410.46

- (1) Physicians' services.
- (2) Services and supplies furnished as an incident to physicians' professional services.
- (3) Nurse practitioner and physician assistant services.
- (4) Services and supplies furnished as an incident to nurse practitioners' or physician assistants' services.
- (5) Visiting nurse services.
- (b) Medicare pays for rural health clinic services when they are furnished at the clinic, at a hospital or other medical facility, or at the beneficiary's place of residence.

§ 410.46 Physician and other practitioner services furnished in or at the direction of an IHS or Indian tribal hospital or clinic: Scope and conditions.

- (a) Medicare Part B pays, in accordance with the physician fee schedule, for services furnished in or at the direction of a hospital or outpatient clinic (provider-based or free-standing) that is operated by the Indian Health Service (IHS) or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act). These services are subject to the same situations, terms, and conditions that would apply if the services were furnished in or at the direction of a hospital or clinic that is not operated by IHS or by an Indian tribe or tribal organization. Payments include health professional shortage areas incentive payments when the requirements for these incentive payments in § 414.42 of this chapter are met.
- (b) Payment is not made under this section to the extent that Medicare otherwise pays for the same services under other provisions.
- (c) Payment is made under these provisions for the following services:
 - (1) Services for which payment is made under the physician fee schedule in accordance with part 414 of this chapter.
 - (2) Services furnished by non-physician practitioners for which payment under Part B is made under the physician fee schedule.
 - (3) Services furnished by a physical therapist or occupational therapist, for which payment under Part B is made under the physician fee schedule.

42 CFR Ch. IV (10–1–09 Edition)

- (d) Payments under these provisions will be paid to the IHS or tribal hospital or clinic.

[66 FR 55329, Nov. 1, 2001]

§ 410.50 Institutional dialysis services and supplies: Scope and conditions.

Medicare Part B pays for the following institutional dialysis services and supplies if they are furnished in approved ESRD facilities:

- (a) All services, items, supplies, and equipment necessary to perform dialysis and drugs medically necessary in the treatment of the patient for ESRD.
- (b) Routine dialysis monitoring tests (i.e., hematocrit and clotting time) used by the facility to monitor the patients' fluids incident to each dialysis treatment, when performed by qualified staff of the facility under the direction of a physician, as provided in § 494.130 of this chapter, even if the facility does not meet the conditions for coverage of services of independent laboratories in part 494 of this chapter.
- (c) Routine diagnostic tests.
- (d) Epoetin (EPO) and its administration.

[51 FR 41339, Nov. 14, 1986, as amended at 56 FR 43709, Sept. 4, 1991; 59 FR 1285, Jan. 10, 1994; 73 FR 20474, Apr. 15, 2008]

§ 410.52 Home dialysis services, supplies, and equipment: Scope and conditions.

- (a) Medicare Part B pays for the following services, supplies, and equipment furnished to an ESRD patient in his or her home:
 - (1) Purchase or rental, installation, and maintenance of all dialysis equipment necessary for home dialysis, and reconditioning of this equipment. Dialysis equipment includes, but is not limited to, artificial kidney and automated peritoneal dialysis machines, and support equipment such as blood pumps, bubble detectors, and other alarm systems.
 - (2) Items and supplies required for dialysis, including (but not limited to) dialyzers, syringes and needles, forceps, scissors, scales, sphygmomanometer with cuff and stethoscope, alcohol wipes, sterile drapes, and rubber gloves.

(3) Home dialysis support services furnished by an approved ESRD facility, including periodic monitoring of the patient's home adaptation, emergency visits by qualified provider or facility personnel, any of the tests specified in paragraphs (b) through (d) of § 410.50, personnel costs associated with the installation and maintenance of dialysis equipment, testing and appropriate treatment of water, and ordering of supplies on an ongoing basis.

(4) On or after July 1, 1991, erythropoiesis-stimulating agents for use at home by a home dialysis patient and, on or after January 1, 1994, by a dialysis patient, if it has been determined, in accordance with § 494.90(a)(4) of this chapter, that the patient is competent to use the drug safely and effectively.

(b) Home dialysis support services specified in paragraph (a)(3) of this section must be furnished in accordance with a written treatment plan that is prepared and reviewed by a team consisting of the individual's physician and other qualified professionals. (Section 494.90 of this chapter contains details on patient plans of care).

[51 FR 41339, Nov. 14, 1986, as amended at 56 FR 43709, Sept. 4, 1991; 59 FR 26959, May 25, 1994; 73 FR 20474, Apr. 15, 2008]

§ 410.55 Services related to kidney donations: Conditions.

Medicare Part B pays for medical and other health services covered under this subpart that are furnished in connection with a kidney donation—

(a) If the kidney is intended for an individual who has end-stage renal disease and is entitled to Medicare benefits; and

(b) Regardless of whether the donor is entitled to Medicare.

§ 410.56 Screening pelvic examinations.

(a) *Conditions for screening pelvic examinations.* Medicare Part B pays for a screening pelvic examination (including a clinical breast examination) if it is performed by a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act), or by a certified nurse midwife (as defined in section 1861(gg) of the Act), or a physician assistant, nurse practitioner, or clinic

nurse specialist (as defined in section 1861(aa) of the Act) who is authorized under State law to perform the examination.

(b) *Limits on coverage of screening pelvic examinations.* The following limitations apply to coverage of screening pelvic examination services:

(1) *General rule.* Except as specified in paragraphs (b)(2) and (b)(3) of this section, payment may be made for a pelvic examination performed on an asymptomatic woman only if the individual has not had a pelvic examination paid for by Medicare during the preceding 23 months following the month in which her last Medicare-covered screening pelvic examination was performed.

(2) *More frequent screening based on high-risk factors.* Subject to the limitation as specified in paragraph (b)(4) of this section, payment may be made for a screening pelvic examination performed more frequently than once every 24 months if the test is performed by a physician or other practitioner specified in paragraph (a) of this section, and there is evidence that the woman is at high risk (on the basis of her medical history or other findings) of developing cervical cancer or vaginal cancer, as determined in accordance with the following risk factors:

(i) High risk factors for cervical cancer:

(A) Early onset of sexual activity (under 16 years of age).

(B) Multiple sexual partners (five or more in a lifetime).

(C) History of a sexually transmitted disease (including HIV infection).

(D) Absence of three negative or any Pap smears within the previous 7 years.

(ii) High risk factor for vaginal cancer: DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

(3) *More frequent screening for women of childbearing age.* Subject to the limitation as specified in paragraph (b)(4) of this section, payment may be made for a screening pelvic examination performed more frequently than once every 24 months if the test is performed by a physician or other practitioner as specified in paragraph (a) of